Fairfield Surgery

Inspection report

High Street
Burwash
Etchingham
East Sussex
TN19 7EU
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www.fairfieldsurgery.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This practice is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced inspection at Fairfield Surgery on 23/04/2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- The practice had a system for destroying their expired controlled drugs that did not put patients at risk. However they had not followed the correct process in contacting the Controlled Drugs Accountable Officer (CDAO).
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Most patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- To deliver training to the whole practice on sepsis recognition and management.
- Review and improve the practice and standard operating procedures (SOP) in respect to the destruction of controlled drugs.
- To ensure that details of how to contact the Parliamentary and Health Service Ombudsman are included in replies to complaints.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Population group ratings

Older people	Good
People with long-term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a CQC medicines inspector.

Background to Fairfield Surgery

Fairfield Surgery is a rural practice offering general medical services to people living and working in Burwash, Etchingham and the surrounding area. The current patient list is pproximately 4100. It is a practice with two GP partners, both male and two salaried GPs one male and one female. This equates to 2.7 full time equivalent GPs.

Additionally the practice employs a regular GP locum to carry out a weekly ward round at a local nursing home.

The practice also has two practice nurses, two healthcare assistants, four dispensary staff, a practice manager and a team of receptionists and administration staff.

The practice offered dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy.

Data available to the Care Quality Commission (CQC) shows the percentage of patients aged 18 and under is just below both clinical commissioning group (CCG) and England averages. Data also shows the percentage of patients over 65 years of age is higher than both the CCG and national averages. The number of registered patients suffering income deprivation (affecting both adults and children) are below CCG and England averages.

The practice is open Monday to Friday between 8am and 6.30pm. Appointments can be booked over the telephone, online or in person at the surgery. Patients are provided information on how to access an out of hour's service by calling the surgery or viewing the practice website.

The practice runs a number of services for its patients including; chronic disease management, new patient checks, child vaccinations, smoking cessation, phlebotomy and postnatal care.

Services are provided from one location:

Fairfield Surgery

High Street

Burwash

Etchingham

East Sussex

TN19 7EU

Further information about the practice and services provided can be found on their website which can be accessed via the following link www.fairfieldsurgery.co.uk

The practice has a General Medical Services (GMS) contract with NHS England. (GMS is one of the three contracting routes that have been available to enable

commissioning of primary medical services). The practice is part of NHS Hastings and Rother Clinical Commissioning Group. Out of hours care is accessed by contacting NHS111.

Fairfield Surgery is registered by CQC to carry out the following regulated activities, Maternity and midwifery services, Treatment of disease, disorder or injury, Surgical procedures and Diagnostic and screening procedures.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Although reception staff were aware of 'red flag' symptoms and when to alert clinical staff, they were not aware specifically of sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines which took place either face to face or by telephone
- Arrangements for dispensing medicines at the practice kept patients safe although staff were not clear of the process for the destruction of stock CDs. They did not know that they required a Controlled Drugs Accountable Officer (CDAO) to attend the destruction of CDs. However, the practice was responsive to our findings and has since contacted their local CDAO. The practice now has contact details of their local Authorised Witness. The Dispensary Lead GP has provided us with three standard operating procedures for the destruction

of CDs which reflect correct practice. The GP has informed us that staff have been made aware of these SOPs and the practice is reflecting on this issue as a significant event.

- No patients or staff were harmed or placed at risk by the practice destroying their own expired stock. The expired stock destroyed was a very small amount and it was recorded and witnessed by practice staff. There was no evidence of diversion of CDs or mis-intent.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall .

Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.

The previous partnership was deregistered with CQC in February 2016. The current senior partner was registered as an individual practitioner between April 2016 and March 2017. However both current partner GPs were working at the practice as partner and salaried GP without any other partner during the period that the QOF data refers to and we therefore refer to this data set in the report.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice engaged in the local vulnerable patients scheme. Older patients who were frail or vulnerable received a full assessment of their physical, mental and social needs and an appropriate care plan implemented. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- All patients over 65 were offered flu vaccinations, if appropriate this could be at home.
- The practice ran a weekly ward round at a local nursing home with 70 beds.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. If necessary this was carried out at a patient's home.
- The practice used NICE (National Institute for Health and Care Excellence) and local guidelines in the management of long term conditions.
- One of the GPs held a surgery weekly with extended appointment times for patients with complex medical conditions.
- The practice held monthly multi-disciplinary team (MDT) meetings with the district nursing team, social services, hospice teams and local carer support agency in attendance.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Registers were retained of all patients with these conditions and they were flagged on the practice computer system.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above in one catagory and just below in three others. The practice had introduced a

system whereby if a parent or guardian of a patient had not responded to three recall letters, the practice followed up with a fourth more personalised letter signed by the GP.
- Community midwives held clinics at the surgery and liaised with the GPs where appropriate in the management of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. The health visitor held a clinic in the surgery and communicated with the GPs where necessary.
- The practice cared for children from a local childrens' home. They retained a list of staff at the childrens' home so that they could easily identify carers. The children were flagged on the computer records.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 77%, which was above the local and England averages. The target for the national screening programme was 80%.
- The practices' uptake for breast and bowel cancer screening was generally above the England average except for one parameter. This was females 50-70 who were screened for breast cancer within 6 months of invitation. However the number screened for breast cancer in the last 36 months was above local and England averages. The practice and patient participation group had worked on a joint venture the previous year to increase awareness of screening.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They also retained lists of and flag the notes of, frail patients, those who have complex medical needs or several chronic diseases and are over 75yrs, those who are in need of palliative care and those with mental health issues.
- All vulnerable patients had a care plan that was reviewed annually with them
- Vulnerable patients who were seen in A&E or were admitted were reviewed and followed up by a call from the GP or the reception team as appropriate. They were be invited to come in to review their care plan if necessary.
- Vulnerable patients were placed on the vulnerable patients scheme for closer monitoring by the GP.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- All patient contacts with Out of Hours services were reviewed by the duty doctor in the morning to assess whether they need to be contacted by the GP.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 84% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the local and England average.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was above the England average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 80% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was below the England average.
- A local counselling service was available on-site.

Good

Are services effective?

- There was access to acute mental health services via the local crises team throughout the day.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Five clinical audits had been carried out in the previous 14 months. Where appropriate, clinicians took part in local and national improvement initiatives. For example they were part of a seven practice federation that worked together and pooled ideas and resources. The partners had regular meetings with the data quality manager and practice manager to monitor the progress of QOF and to identify areas that needed improvement.

- The practice were a positive outlier for one QOF indicator: The percentage of patients with significant mental health concerns that had had a care plan documented was 100% (CCG average 87.9%, England average 90.3%)
- The practice used information about care and treatment to make improvements.

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They demonstrated how they kept up to date.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. For example the practice had employed a dedicated GP to carry out weekly ward rounds at a large local nursing home. They shared information with, and liaised, with community services, social services and carers for housebound patients. They also liaised with health visitors and community services with respect to children and families in vulnerable situations. They provided care for the residents of a local children's' home.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

Good

Are services effective?

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

The previous partnership was deregistered with CQC in February 2016. The current senior partner was registered as an individual practitioner between April 2016 and March 2017. However both current partner GPs were working at the practice as partner and salaried GP without any other partner during the period that the National GP Survey data refers to and we therefore refer to this data set in the report.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were made available if requested.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

Privacy and dignity

The practice respected/did not respect patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room or area to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

The previous partnership was deregistered with CQC in February 2016. The current senior partner was registered as an individual practitioner between April 2016 and March 2017. However both current partner GPs were working at the practice as partner and salaried GP without any other partner during the period that the National GP Survey data refers to and we therefore refer to this data set in the report.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations with GPs were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment.
- The practice regularly communicated with the local district nursing team and met them at monthly multi-disciplinary team meetings. This allowed discussion of how to manage the needs of patients with complex medical issues.
- The practice offered monitoring services including the monitoring of patients on anti-coagulants (medicines to thin the blood).

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered a range of online services such as ordering repeat prescriptions and booking appointments.
- Patients can book telephone appointments with the GP.
- Urgent appointments were available towards the end of the working day.
- Chlamydia testing kits were made available in the practice.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances would be able to register with the practice, including those with no fixed abode.

People experiencing poor mental health (including people with dementia):

Good

Are services responsive to people's needs?

- A local counselling service was available on-site.
- The practice carried out a weekly ward round at a nursing home which had a large number of patients living with dementia.
- The practice referred patients whom they suspected of having dementia to the local memory service or elderly care psychiatry team.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance although information on how to complain to the ombudsman was not always inserted in to letters. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical

staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group and friends of Fairfield Surgery group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.